J-1 Visa Physician's Name: _____

Date Sent: _____ Reporting Period: _____

Kentucky State-30 J-1 Visa Waiver Program
Six Month Reporting And Exit Form

1. EMPLOYER/SPONSOR:

Name_____
Mailing Address_____
City, State, Zip_____
Telephone # with Area Code_____
Original Date of Employment_____

2a. PRACTICE SITE(S):

	Primary Site	Additional Site (If more than 2 practice sites, list on back of this page)
Practice Name		
Street Address		
City, State, Zip		
Telephone # with Area Code		
Original Date of Employment		
# Office Hours/Week (Do not include on-call status or travel.)		

2b. Enter daily office hours* (include administrative time) by location:

Sunday _____ Monday _____ Tuesday _____ Wednesday _____
Thursday _____ Friday _____ Saturday _____

***Do not include time spent in an on-call status or travel in practice hours.**

2c. Average hours worked per week at approved practice: _____

2d. Average hours worked per week treating patients at hospital: _____

2e. List the names and location of any nursing homes you are currently serving:

_____

_____

_____

3. Number of total patient encounters (visits)* by source of payment:

i. Medicare (exclude # M'care crossover to M'caid visits): _____
ii. Medicaid (include # M'care crossover to M'caid visits): _____
iii. Full-pay and Commercial Insurance: _____
iv. Sliding Fee Scale or Other Reduced Pay _____
v. No-pay: _____
vi. Other: _____
vii. Total _____

*Include office, hospital, nursing home, and home visits.

4. Number of Kentucky Physicians Care patients seen. _____

5 During this reporting period, state the number of weeks not at approved practice due to illness, vacation, or continuing medical education. _____

6.a. Estimated percent of Medicare patients from whom you accepted assignment: _____.

6.b. If 6.a. is less than 100 percent, please explain the circumstances:

_____

_____

_____

6.c. Do you accept assignment under Part B of Medicare as full payment for services? (circle correct choice):

1 - Yes 2 - No

7. Is a notice posted in your waiting room stating that a sliding fee scale or similar arrangement to reduce charges based on family income is employed by your practice, and that patients will be treated regardless of the ability to pay? (circle correct choice):

Yes 2 – No

8. During reporting period, how many additional hours were outside of approved practice(s) (e.g., local emergency room)? _____

Date report completed (mm/dd/yy): _____/_____/_____

Signature of J-1 Service Participant: _____

Print/Type Full Name of J-1 Service Participant: _____

AFTER COMPLETING THIS REPORT AND SECURING EMPLOYER ACKNOWLEDGEMENT OF REVIEW OF COMPLETED REPORT, **PLEASE RETURN WITHIN (10) DAYS OF RECEIPT TO:**

JOHN HENSLEY or DEBBIE BOHANNON
DEPARTMENT FOR PUBLIC HEALTH
DIVISION OF ADULT AND CHILD HEALTH
HEALTH CARE ACCESS BRANCH
275 EAST MAIN STREET HS2GW-A
FRANKFORT, KENTUCKY 40621
Phone (502) 564-4830 Fax (502) 564-8389

EMPLOYER ACKNOWLEDGEMENT OF REVIEW OF COMPLETED ANNUAL REPORT:

Date of Review _____/_____/_____

_____
Signature of Employer Representative

_____
Name Printed or Typed

_____
Position or Title

_____
Name of Employing Organization/Practice

WAIVER APPLICANT EXIT INTERVIEW

PLEASE COMPLETE THIS SECTION ONLY IF YOU HAVE OR WILL BE EXITING THE J-1 STATE 30 WAIVER PROGRAM DURING THIS 6 MONTH REPORTING PEROID.

Date of Original Employment: _____

Completion Date of ARC Waiver: _____

Do you plan to stay in the area to practice? ☐ YES ☐ NO

Please briefly describe your experience during the term of your contract: _____

_____

_____